STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Maine

PAYMENT RATES FOR CARE AND SERVICES OTHER THAN INPATIENT HOSPITAL

(REVISED)

1. Inpatient hospital services - see Attachment 4.19-A

2. a. Outpatient hospital services - Same as Attachment 4.19-A.

   b. Certified Rural Health Clinics, are reimbursed in accordance with 42 CFR 447.371(a) and (C)(2). Rural health clinic services which are "provider clinics" will be reimbursed at a reasonable cost rate in accordance with reimbursement principles for that provider. Non-provider clinics are reimbursed for rural health clinic services at the per visit established by Medicare, and for other ambulatory care services on the basis of a fee schedule established by the state agency for other providers of these services. See Attachment 4.19-B, Physician (and other prescribers) Directed Drug Initiative (PDDI), pages 1-b to 1-d.

   c. Federally Qualified Health Center (FQHC) Services are reimbursed at a reasonable cost rate in accordance with the Medicare principles of reimbursement. An annual per visit cap is determined by the Department. See Attachment 4.19-B, Physician (and other prescribers) Directed Drug Initiative (PDDI), pages 1-b to 1-d.

3. Other laboratory and X-ray services - the same as under Physicians' services, Item 5.

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4. a. Skilled Nursing Facility services(other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older. See Attachment 4.19 D.

   b. Early and Periodic Screening, Diagnosis and Treatment Services - The State agency will apply the rates currently in effect for the item of service provided, except the rates of payment for agencies participating in the EPSDT program under special agreements is made on the basis of a negotiated fee schedule.

   c. Family Planning Services and Supplies - The State agency will apply the payment rate as described in Attachment 4.19 A when provided by a hospital, and as described in Item 5 below when provided as physician's services. Family Planning Agencies are reimbursed on the basis of a fixed fee schedule.

5. Physicians' Services - The State agency will apply a fee schedule, which will reflect a relative value scale determination of statewide charges of physician services. In establishing this fee schedule, the Department shall make an effort to consult with individual providers or their representative associations.

   a. The Fee Schedule - Insure that payment will not exceed the lower of: the fees set by Medicare, the physician provider charges, or the Maine Medicaid established fee.

   b. In addition, The State agency will implement Physician Feedback Report And Incentive Awards as described below.

      Elements Of Physician Feedback Report

      1. ACCESS (40 percent)
         a. Total number of unduplicated Medicaid recipients served per quarter year .
         b. Total number of health care providers accepting new Medicaid recipients.

PAYMENT RATES FOR CARE AND SERVICES OTHER THAN INPATIENT HOSPITAL

2. UTILIZATION (30 percent)

Emergency visit rate per quarter for physicians unduplicated Medicaid recipients per quarter.

3. QUALITY (30 percent)

a. Preventive measures score higher.
b. Comparison of Quality Indicators (QI) amongst specialty groups.

Examples:

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Childhood immunization - percentage of children in the practice immunized by age 2 against DPT, polio, measles/mumps/rubella, type B influenza, and hepatitis B.

Adolescent immunization - percentage of practice's children recipients who have had following immunization by age 13: second dose of measles/mumps/rubella, hepatitis B, tetanus/ diphtheria booster, and chicken pox.

Prenatal Care - percentage of women in practice who delivered a baby in previous year and received prenatal care in the first trimester.

Post-delivery checkup - percentage of mothers in practice who had a checkup within six weeks after delivery.

Mammography - percentage of women in practice ages 52 to 69 who had a mammogram in previous year.

Pap test - percentage of women in plan ages 21 to 64 who had a Pap test for cervical cancer in previous year.

Board certification - percentage of practice board certified in appropriate discipline.

The specific indicators utilized will be selected quarterly as necessary to obtain targeted quality of care evaluations. The same criteria shall be used amongst similar groups of physicians, i. e., Family Practitioners/General Practitioners, Internal Medicine, Pediatrics, etc.

4. PATIENT SATISFACTION (per cent allocation to be determined in second year of physician assessment)

a. Percentage of recipients who change primary physician.
b. Percentage of recipients who report they are completely or very satisfied with their care.

DETERMINATION OF PHYSICIAN INCENTIVE AWARDS

The elements described above will be the basis for placing each participating Medicaid physician in a octal as follows:

GROUP 1	PERCENTILE	SIXTY PERCENT OF TOTAL AWARD (60%)
Octal 1	90 - 100	30% of group 1 award
Octal 2	80 - 89	20% of group 1 award
Octal 3	70 - 79	10% of group 1 award

PAYMENT RATES FOR CARE AND SERVICES OTHER THAN INPATIENT HOSPITAL

GROUP 2	PERCENTILE	TWENTY-FIVE PERCENT OF TOTAL AWARD (25%)
Octal 4	60 - 69	10% of group 2 award
Octal 5	50 - 59	8% of group 2 award
Octal 6	40 - 49	7% of group 2 award

GROUP 3	PERCENTILE	FIFTEEN PERCENT OF TOTAL AWARD (15%)
Octal 7	30 - 39	10% of group 3 award
Octal 8	20 - 29	5% of group 3 award

NO AWARD FOR 0 - 19 PERCENTILE

b. PHYSICIAN (AND OTHER PRESCRIBERS) DIRECTED DRUG INITIATIVE (PDDI)

Elements Of Physician (And Other Prescribers) Directed Drug Initiative

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Analysis of the first quarter's data will take place in May-June, 2000. Claims and subsequent payments, if any savings occur, will be issued 90-120 days following the end of each quarter. BMS will determine savings based upon actual prescribing patterns within drug categories for all practitioners aggregated together. Physicians and other prescribers will be compared to other prescribers in their specialty and will be evaluated based upon the use of cost saving therapeutic alternatives, frequency of generic prescribing, and reduction in use of brand name drugs for which there are therapeutically equivalent generics. Payment will occur if there are net savings in the specific group of drugs targeted or in a particular therapeutic class as long as health care outcomes are maintained or improved. Physicians and other prescribers who perform well under this program should expect to receive 40% of the net savings generated in the aggregate.

Methodology

Elements Of The Program Consist Of Two Pools Of Savings Available From The Initiative: 1) Specific Drug Category Savings, And 2) Non-Specific Drug Category Savings.

1) Within the Specific Drug Category Savings there are two means of distribution:

- The Specific Drug Category distribution, and the
- Specific Drug Category per month per member (PMPM) distribution.

2) The methodology for the Non-Specific Drug Category is the PMPM distribution.

Any savings from the Specific Drug Category PMPM will be added to the Non-Specific Drug Category PMPM distribution.

These distributions are not dependent upon any one discrete claim or patient; rather they are reflective of the combined drug utilization profiles, drug outcomes and medical outcomes across the prescriber's entire patient panel. The health outcomes of the Medicaid population are protected since no savings are distributed to any participant unless maintained or improved quality is demonstrated.

PAYMENT RATES FOR CARE AND SERVICES OTHER THAN INPATIENT HOSPITAL

Specific Drug Categories (SDCs) have appropriate therapeutically equivalent drugs with substantially different prices. Program costs for the Specific Drug Categories are monitored and savings are calculated within the categories. Relative pricing information and clinically appropriate patient/drug selection guidelines are shared with the prescribers for the Specific Drug Categories.

Initially, The List Of Specific Drug Categories Includes These Examples:

H2 Blockers/ Proton Pump Inhibitors
ACE Inhibitors/Calcium Channel Blockers/Beta Blockers and other antihypertensives
Statins
NSAIDS
Antidepressants
Antibiotics
Antihistamines
Nasal Steroids
Inhaled Steroids
Other categories will be added

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Any net savings created within a Specific Drug Category created by a decrease in the value per unit cost will be redistributed to eligible prescribers according to the Specific Drug Category distribution formula described below. This distribution will occur regardless of whether any savings occur in other drug categories.

Two pools of savings dollars will be available from the Initiative: Specific Drug Category Savings and Non-Specific Drug Category Savings. Within the Specific Drug Category Savings there are two methods of distribution, the Specific Drug Category distribution and the Specific Drug Category PMPM distribution. The methodology for the Non-Specific Drug Category is the PMPM distribution. Approximately 85% of the savings is expected to come from Specific Drug Categories, and 15% from the Non-Specific Drug Categories. Any savings from the Specific Drug Category PMPM will be added to the Non-Specific Drug Category PMPM distribution. These distributions are not dependent upon any one discrete claim or patient; rather they are reflective of the combined drug utilization profiles, drug outcomes and medical outcomes across the prescriber's entire patient panel. The health outcomes of the Medicaid population are protected (ensured) since no savings are distributed to any participant unless maintained or improved quality is demonstrated. Conversely, it is important to note that even providers who do not create drug savings may receive an award if their quality medical or drug outcomes are superior to their peers.

For each specific drug category a baseline cost per unit prescribed will be calculated for all drugs in the category for an individual prescriber. Savings can not simply be redistributed on the basis of generic prescription volume since not all drug categories have generics. Furthermore, savings generated by changes within brand name drugs also need to be recognized.

If the individual prescriber's value/unit or cost for Period 2 is less than the aggregate value/unit for the initial period 1, they are eligible for a distribution, otherwise they are not eligible for a distribution. The distribution is 40% of the difference in cost per unit multiplied by the number of units.

Drug Outcomes/Medical Outcomes Analysis:

In the first year of the Initiative, any prescriber who is eligible for a distribution share on the basis of generating savings is then subject to a drug outcome quality assessment. Each provider is compared to their peers across their relevant range of targeted conditions (ex. - family doctors, CHF, AFIB, DM, asthma, etc.). Any provider not performing above the mean or within one standard deviation below the mean would not receive a distribution.

PAYMENT RATES FOR CARE AND SERVICES OTHER THAN INPATIENT HOSPITAL

The exception to this policy is when a provider who finishes more than 1 SD below the mean for their specialty has nevertheless improved on their own or their specialty's baseline drug outcomes. Starting with the second year (to allow for claims lag) similar performance thresholds will also apply for all relevant medical outcomes in order for an award to occur.

Savings from units prescribed are transformed to non-specific savings. Savings distributions in the Non-Specific Drug Category are also tied to quality outcomes. Distributions occur only if desired drug outcomes (DDO) or desired medical outcomes (DMO) are maintained or improved. Prescribers with better than average PMPM drug profiles receive a distribution unless DDO or DMO quality scores are greater than 1 standard deviation below the mean for their specialty. Prescribers with below average PMPM drug profiles do not receive a distribution unless their DDO or DMO is greater than 1 standard deviation above the mean for their specialty.

A third category of Quality Adjustment is the Dispensed As Written (DAW1) adjustment. Prescribers may restrict prescriptions to dispense only the brand name for a medication. The average DAW1 rate is calculated; an adjustment is made for prescribers with DAW1 rates greater than 1 standard deviation above the mean for their specialty. Additionally, adjustments need to be made for the size of the population eligible to take the medications through the use of the user/eligibility ratio. For conditions where increased utilization is desired, no adjustment is necessary, as, for example CHF and ACE Inhibitors. For certain over utilized medications, such as antibiotic use for upper respiratory infections or use of H2Bs/PPIs, an adjustment to the savings available for distribution is made based on the amount of increase in the user/eligibility ratio.

6. a. Podiatrists' - Payment is made on the basis of a fixed fee schedule, but not to exceed the 75h percentile established by Medicare B.

   b. Optometrists' - Payment is made on the basis of a fixed fee schedule, but not to exceed the 75th percentile established by Medicare B.

   c. Chiropractors - Payment is made on the basis of a fixed fee schedule, but not to exceed the 75th percentile established by Medicare B.

   d. Psychologists - Payment is made on the basis of a fixed fee schedule, but not to exceed the 75th percentile established by Medicare Part B.

7. a. Home Health Care Services - Intermittent or part time nursing and nursing aide services furnished by a home health agency. The State agency will apply the same standards, cost reporting period, cost reimbursement principles, and method of cost apportionment currently used in computing reimbursement for Home Health Care Agencies under Title XVIII of the Social Security Act.

   b. Intermittent part time nursing services of a professional R.N. or L.P.N. when no Home Health Agency is available to provide the Service - The State agency will make payments based upon a fee schedule which reflects usual and customary charges for these services.

   c. Medical Supplies, equipment, and appliances for use of patients in their own home, payments are made on the same basis as 7b.

8. Private Duty Nursing - Payment is made on the basis of a fixed fee schedule. The amount of private duty nursing services will be capped per individual on an annual basis as determined by the Department.

9. Clinic Services - Payment is made on the basis of a fixed fee schedule.

10. Dental Services - Payment for these services is made on the basis of a fixed fee schedule.

11. Physical Therapy and related services.

   a. Physical Therapy - Payment is made on the basis of a fixed fee schedule, but not to exceed the 75th percentile established by Medicare Part B.

   b. Occupational Therapy - Payment is made as described in 11a.

   c. Services for individuals with speech, hearing, and language disorder - The State Agency will make payments as in 11a above.

PAYMENT RATES FOR CARE AND SERVICES OTHER THAN INPATIENT HOSPITAL

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs - Payment is made at the lowest of the following (1) Estimated Acquisition Cost (EAC) plus professional fee, (2) Maine Maximum Allowable Cost (MMAC) plus professional fee, (3) Federal Upper Limits (FUL) plus professional fee, or (4) the provider's usual and customary charge or any amount the provider will accept from any other third party program as from the public in the form of discounts, special rebates, incentives, coupons, club plans or contracts with the exception of senior citizen discounts. Reimbursement for compound drugs is based upon a professional compounding fee and the cost of ingredients.

Note: Estimated Acquisition Cost (EAC) is defined as the average wholesale price (AWP) minus 10 per cent.

For pharmacy providers dispensing medications to recipients residing in nursing facilities, ICFs/MR and boarding homes for which Medicaid is billed, reimbursement is at average wholesale price minus 7 1/2% when charges are for the actual doses administered, otherwise reimbursement is the EAC, with one dispensing fee per month.

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Dispensing Fees are as follows:

(1) Without Point of Purchase Program:

i. $3.35 for an amount dispensed from a stock supply, or for solutions or lotions involving no weighing.
ii. $5.35 for compounding handmade suppositories, powder papers, capsules and tablet triturates and for mixing home TPN hyper-alimentation.

iii. $4.35 for compounding ointments and for solutions or lotions involving weighing one or more ingredients and mixing home intravenous (IV) solutions.

For pharmacies not utilizing the point of purchase program, paper claims may be submitted. However all the State's edits including those of OBRA 90 such as Prospective Drug Utilization Review, must still be provided at the time of service.

(2) With Point of Purchase Program:

i. $3.10 for an amount dispensed from a stock supply, or for solutions or lotions involving no weighing.
ii. $5.10 for compounding handmade suppositories, powder papers, capsules and tablet triturates and for mixing home TPN hyper-alimentation.
iii. $4.10 for compounding ointments and for solutions or lotions involving weighing one or more ingredients and mixing home intravenous (IV) solutions.

For pharmacies utilizing the State's Point-Of-Purchase program, the dispensing fee covers services provided by the State to the pharmacy at the time of dispensing the prescription and includes such services as:

PAYMENT RATES FOR CARE AND SERVICES OTHER THAN INPATIENT HOSPITAL

- current recipient eligibility verification,
- current drug coverage under the HCFA rebate program,
- current compliance with the State's Medicaid drug program rules including Prospective Drug Utilization Review requirements,
- a review of all prescriptions filled throughout the entire Medicaid system,
- a payment within seven (7) days of prescription filling/claim submittal, and
- prospective reimbursement amount returned to the pharmacy provider before dispensing the prescription.

b. Dentures - See item 10 above.

c. Prosthetic Devices - The State Agency will make payments based upon the acquisition cost for these devices.

d. Eyeglasses - Payment is made on the basis of a fixed fee schedule, but not to exceed the 75th percentile established by Medicare Part B.

13. Other diagnostic, screening, preventive and rehabilitative services - The State agency will apply the payment rate as described in Attachment 4.19-A when provided by a hospital and as described in Item 5 above when provided as Physicians' Services.

Rehabilitation Services:

a. Private non-medical institutions - Payment is made under contracts which are based on capitation rates.

b. Mental health Clinic services - Payment is made based on negotiated rates.

c. Substance Abuse Treatment Services - Payment is made based on fee-for-service rates.

d. Day Health Services - Payment is made based on a fixed fee schedule.

e. Rehabilitation Services - Payment is made based on a negotiated fee schedule.

f. Early Intervention Services - Payment is made based on a negotiated fee schedule.

g. Home Based Mental Health - Payment is made based on a negotiated fee schedule.

h. School Based Rehabilitation Services - Payment is made on the basis of a fixed fee schedule. The fee shall be based on a gobal rate for each month specific to identified conditions.

i. Residential Services - payment is made on a negotiated schedule.

14. Skilled and intermediate care nursing services for individuals 65 years of age or over in an institution for mental disease - See Attachment 4.19-D.

15. Nursing Facility Services - (other than in institutions for mental disease as described under #14 above) - See Attachment 4.19-D.

16. Inpatient Psychiatric Hospital Services for individuals under 22. See attachment 4.19-A(under inpatient Hospital Services).

17. Nurse-midwives - Payment is made on the basis of a fixed fee schedule.

PAYMENT RATES FOR CARE AND SERVICES OTHER THAN INPATIENT HOSPITAL

18. Any other medical care and any other type of remedial care recognized under State law:

    a. Ambulance Services - Payment is made on the basis of a fixed fee schedule, but not to exceed the 75th percentile established by Medicare Part B.

    b. Services of Christian Science Nurses - payments will be based on a fee schedule which reflects usual and customary charges for these services.

    c. Care and Services in Christian Science Sanitaria - The State agency will apply payment rates currently in effect under Title XVIII.

    d. Skilled Nursing Facility Services to patients under 21 - See Attachment 4.19-D.

    e. Emergency Hospital Services - The State agency will apply the payment rate as described in Attachment 4.19-A.

    f. Personal Care Services:

        1. Payment is made on the basis of a fixed fee schedule. The amount of personal care services in combination with home health services and private duty nursing services will be limited to an annual cap as determined by the Department.

        2. Payment for personal care services provided by a private non-medical institution are made under contracts authorizing a capitation rate.

19. Transportation Services - Payment is made on the basis of a fee schedule.

20. Case Management Services - All payment rates for case management services are based on a cost report submitted by the provider. The payment rate will be calculated using allowable/reimbursable costs appropriate to the provider, as determined by the Department.

21. Certified family and pediatric nurse practitioners - Payment is based on the established fee schedule for Physicians' Services as described in Item 5.

State: MAINE

ASSURANCES RELATING TO THE ADEQUACY OF PAYMENT LEVELS FOR OBSTETRICAL AND PEDIATRIC SERVICES

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Maine's Department of Human Services has set rates in response to problems of access, especially in the area of obstetrical care. The current rates of reimbursement were established as of May of 1992 and were set as high as current funding levels allowed.

Maine has developed a mechanism to increase Medicaid reimbursement rates in a fair and reasonable manner.

The Department of Human Services has worked with a Physician's Advisory Workgroup to develop a method for refining physician payments to achieve three major objectives:

1. to increase Medicaid physician payments;

2. to achieve greater equity in Medicaid physician fees by reducing unjustified differences in fees among and within medical specialties; and

3. to increase access to medical care for Medicaid recipients.

Through the work of the Muskie Institute of the University of Southern Maine, a framework for the restructuring of Medicaid physician fees was developed. This framework is based on the Harvard Resource Based Relative Value System study.

In addition to this work, DHS has received the results of a study to determine Medicaid obstetrical access. The following measures were studied:

Utilization	volume of births by geographic area location of prenatal care volume and types of services by gepgraphic area
Access	volume and type of physicians providing OB care by geographic area volume of patients per provider per year
Outcome	linking birth certificate date and provider data to Medicaid claims to determine trends in adequacy of care

Maine incorporated prenatal care case management under a managed care program to ensure access and better prenatal care.